

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1075

CERTIFICATE OF DEATH

01081

Reg. Dist. No.

| | | | | | | | | | |
|--|--|---|---|---|---|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Queen Anne | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Queen Anne | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Price Station | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Price Station | | d. STREET ADDRESS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First Herbert | Middle | Last Cain | 4. DATE OF DEATH Jan. | Month 14 | Day 1959 | Year | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 8, 1877 | 9. AGE (In years lost birthday) 81 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days | 12. IF UNDER 24 HRS. Hours | 13. CITIZEN OF WHAT COUNTRY? USA |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Viscose Prod. | | 11. BIRTHPLACE (State or foreign country) Queen Anne Co., Md. | | 12. FATHER'S NAME Albert Cain | | | |
| 13. MOTHER'S NAME Jessie Cain | | 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 171-10-6239 | | 17. INFORMANT Mrs. Fannie West, New York City, N.Y. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 | | DUE TO Cardiac Failure | | INTERVAL BETWEEN ONSET AND DEATH 3 mo | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | (b) DUE TO Arterio Scleriosis Generalized years (c) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Centreville | (County) | (State) | | | |
| 21. I certify that I attended the deceased from alive on <u>Sept 12</u> , 1959, to <u>Nov 12</u> , 1959, that I last saw the deceased and that death occurred at <u>Centreville</u> , M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>C. Rodney Bayton</u> PHYSICIAN'S NAME (Type) <u>C. Rodney Bayton</u> | | ADDRESS (Street, city or town, state) <u>Centreville, Maryland</u> | | | | | | DATE SIGNED <u>1-16-59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/17/1959 | 22c. NAME OF CEMETERY OR CREMATORIUM Church Hill Cemetery | 22d. LOCATION (City, town, or county) Queen Anne County, Md. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert M. Hollingshead</u> | | ADDRESS Cambridge, Md. | 24a. REC'D BY REGISTRAR JAN 19 1959 | 24b. REGISTRAR'S SIGNATURE <u>John S. Moore</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

31 BROWNSTONE-STEAM TO THE MOUNTAIN 1910

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01082

1076 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|--|--|--|---|--|--|---|---|------------------------------|-----------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> | | b. COUNTY <i>Baltimore</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrisonville</i> | | c. LENGTH OF STAY IN 1b <i>all of life</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garrisonville</i> | | d. STREET ADDRESS <i>Garrisonville</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hospital</i> | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>James Thomas Carter</i> | | First <i>James</i> | Middle <i>Thomas</i> | Last <i>Carter</i> | 4. DATE OF DEATH <i>Jan 1 1959</i> | Month <i>Jan</i> | Doy <i>1</i> | Year <i>1959</i> | |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Mar 7 1901</i> | 9. AGE (in years last birthday) <i>57 yrs.</i> | 10. IF UNDER 1 YEAR Months <i>10</i> | 11. IF UNDER 24 HRS. Days <i>24</i> | Hours <i>00</i> | Min. <i>00</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fisherman</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Oysterman</i> | | 11. BIRTHPLACE (State or foreign country) <i>Green and County Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | | |
| 13. FATHER'S NAME <i>James Carter</i> | | 14. MOTHER'S MAIDEN NAME <i>Melvinia Haddack</i> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>29-03-7549</i> | | 17. INFORMANT <i>James L. Carter</i> | | Address <i>Garrisonville Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>410X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) | | mitral regurgitation | | | | INTERVAL BETWEEN ONSET AND DEATH <i>24</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Jan 1 1959</i> | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) <i>Garrisonville</i> | | (County) <i>Caroline</i> | (State) <i>Md.</i> |
| 21. I certify that I attended the deceased from _____, 19_____, to Jan 1 1959, that I last saw the deceased alive on _____, 19_____, and that death occurred at 7:15 P.M., from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) <i>Garrisonville Md.</i> | | DATE SIGNED <i>1/3-55</i> | |
| ACTUAL SIGNATURE <i>W. Henry Fisher</i> | | M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>absent from med. Exam for 2 weeks</i> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Jan 1 1959</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Brown Chapel Cemetery, Garrisonville Md.</i> | | 22d. LOCATION (City, town, or county) <i>Garrisonville</i> | | (State) <i>Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Miller</i> | | ADDRESS <i>100 W. Main Street, Garrisonville Md.</i> | | 24a. REC'D. BY REGISTRAR DATE <i>JAN 6 1959</i> | | 24b. REGISTRAR'S SIGNATURE <i>John W. Miller</i> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01083

1077

CERTIFICATE OF DEATH

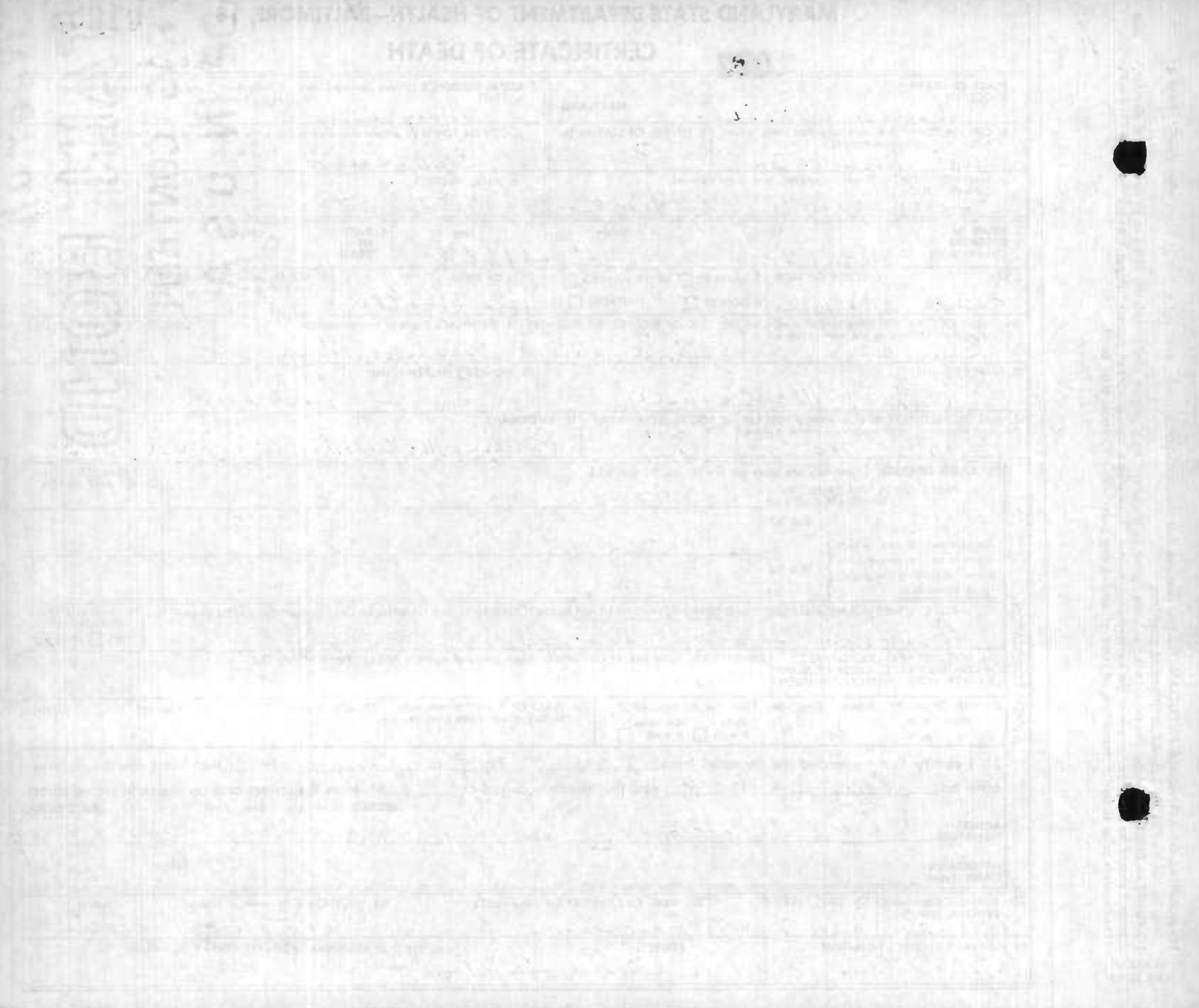
Reg. Dist. No.

| | | | | | | | |
|---|-------------------------|--|---|--|------------------------------------|--|------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | | | | |
| Queen Anne's MARYLAND | | b. COUNTY | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN lb | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | |
| Rural Maryland | ? | Crossfield Somerset | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | | | | | |
| Sally Wren Nursing Home | | 4th St | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | Middle | | | | |
| MARTHA | | COLLISON | | | | | |
| 4. DATE OF DEATH | | Month | Day | | | | |
| | | JAN | 25 | | | | |
| | | 1959 | | | | | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days |
| Female | | Light | | Aug 31-1900 | 58 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Seaford | | Shuck Dyster | | Crossfield Md | | USA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MALENAME | | | | | |
| Robert McCready | | Sara Palmer | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| No | | 7 | | Pauline McCready | | Crossfield Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Crossfield Hemorrhage | | | | | |
| 422.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | Crossfield Arterial Occlusion | | | | | |
| DUE TO | | Crossfield Arterial Occlusion | | | | | |
| (b) | | | | | | | |
| DUE TO | | | | | | | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| Previous cerebral hemorrhage 10 mo. ago | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter picture of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 21 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 14</u> to <u>Jan 25</u> that I last saw the deceased alive on <u>Jan 24</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) | | DATE SIGNED | | | | | |
| ACTUAL SIGNATURE | | P. D. McElroy | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORIUM | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | Jan-28-59 | | Lawsonia | | Crossfield Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | | | | |
| Edward Baileyston Bros (Crestview) Md | | FEB 2 '59 | | | | | |
| 24a. REC'D BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE | | | | | |
| | | Armen S. Kraus | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HOMELAND SECURITY
CERTIFICATE OF PAPER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01084

Reg. Dist. No.

| | | | | | | | | |
|--|---|--|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i> | 1078 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> | b. COUNTY <i>Queen Anne's</i> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wm Price</i> | c. LENGTH OF STAY IN 1b <i>6 weeks</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i> | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i> | | d. STREET ADDRESS <i>1413 S Liberty St</i> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>JAMES LINWOOD FOWLER</i> | First <i>JAMES</i> | Middle <i>LINWOOD</i> | Last <i>FOWLER</i> | 4. DATE OF DEATH Month <i>Jan</i> | Day <i>20</i> | Year <i>1959</i> | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Apr 30 - 1873</i> | 9. AGE (In years lost birthday) yrs. <i>85</i> | 10. IF UNDER 1 YEAR Months <i></i> | 11. IF UNDER 24 HRS Days <i></i> | 12. IF UNDER 24 HRS Hours <i></i> | 13. IF UNDER 24 HRS Min. <i></i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i> | 11. BIRTHPLACE (State or foreign country) <i>Worton, Kent Co Maryland</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 13. FATHER'S NAME <i>James Fowler</i> | 14. MOTHER'S MAIDEN NAME <i>Sarah Katherine Bayer</i> | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i></i> | 16. SOCIAL SECURITY NO. <i>74-700-7000</i> | 17. INFORMANT <i>Mr. Kenneth Fowler, Executor, Clayton, Delaware</i> | Address <i></i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO - DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | INTERVAL BETWEEN ONSET AND DEATH <i></i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i></i> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Veracayxus Reipp died Lutrin - Selenium - Chroogic Decreased desire gets heart</i> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Jan 14, 1959, to Jan 20, 1959, at home</i> | 20f. (City or town) <i></i> | (County) <i></i> | (State) <i></i> | | | |
| 21. I certify that I attended the deceased from <i>Jan 14, 1959</i> to <i>Jan 20, 1959</i> , that I last saw the deceased alive on <i>Jan 19, 1959</i> , and that death occurred at <i>Chestertown</i> , M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. F. McPherson</i> | PHYSICIAN'S NAME (Type) <i>H. F. McPherson</i> | 22d. LOCATION (City, town, or county) <i>Chestertown</i> | 22e. DATE SIGNED <i>1/21/59</i> | | | | | |
| 22b. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22d. DATE THEREOF <i>Jan 23 '59</i> | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Chestertown</i> | 22d. LOCATION (City, town, or county) <i>Chestertown</i> | 22e. DATE SIGNED <i>1/21/59</i> | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W. E. and Son, Chestertown, Md.</i> | ADDRESS <i></i> | 24a. REC'D BY REGISTRAR DATE <i>JAN 23 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>John E. Kuhn</i> | | | | | |

ST. PETERSBURG - HEADQUARTERS OF THE RUSSIAN ARMY

DEPARTMENT OF STATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01085

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|--|---|-----------------|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 1079 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| Queen Anne's | | MARYLAND | | a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b 5 years | | b. COUNTY Queen Anne's | |
| RFD Meltington | | x RFD Centreville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) QR INSTITUTION | | d. STREET ADDRESS 1 Berrsville | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Mary Potts Nursing Home | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First KATIE | Middle BLAKE | Last GARDNER | 4. DATE OF DEATH Jan 1 1959 |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Do not know |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | | 11. BIRTHPLACE (State or foreign country) Berrsville Md | 9. AGE (In years lost birthday) about 75 yrs. |
| Housework | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Emery Blake | | 14. MOTHER'S MAIDEN NAME Dolley Wright | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Fred Bagshaw, 5, RFD Centreville Md | |
| | | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 10 year | | | |
| 420.0 | | Arteriosclerotic Heart Disease | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | 20 year | | | |
| (b) | | General Arteriosclerosis | | | |
| (c) | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury | | | |
| 20c. TIME OF INJURY Hour o. m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Berrsville | |
| 19 | | | | (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 10, 1958, to Jan 1, 1959, that I last saw the deceased alive on Dec 30, 1958, and that death occurred at 3:30 A.M., from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE H. H. HAMILTON | | M.D. | | ADDRESS (Street, city or town, state) Berrlington Md | |
| PHYSICIAN'S NAME (Type) H. H. HAMILTON | | DATE SIGNED 1/3/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan 4 59 | | 22c. NAME OF CEMETERY OR CREMATORIAL Berrsville | |
| | | | | 22d. LOCATION (City, town, or county) RFD Centreville Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. H. HAMILTON | | ADDRESS Berrlington Md | | 24a. REC'D BY REGISTRAR DATE JAN 7 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE O. H. HAMILTON | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01086

1080

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | |
|---|---|--|--|---|-------------|---------|
| 1. PLACE OF DEATH a. COUNTY Queen Anne | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Ind. | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville | | b. COUNTY Queen Anne | | | | |
| c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) | First JAMES | Middle DERIOUS | Last JEROME | | | |
| 4. DATE OF DEATH | Month JAN. | Day 18 | Year 1959 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 4-1862 | | | |
| 9. AGE (In years last birthday) 96 yr. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN | 11. KIND OF BUSINESS OR INDUSTRY | 12. BIRTHPLACE (State or foreign country) MARYLAND | | | |
| 13. FATHER'S NAME JOHN JEROME | 14. MOTHER'S MAIDEN NAME PHOEBE COPPER | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT JACK GARDNER | Address CHESTER MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Cerebral Hemorrhage | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cerebral Arterial Spasm | | | | | | |
| DUE TO (c) Clonic Tug & convuls | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>) | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY | Month, Day, Year | 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| Hour o. m. p. m. | 19 | White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | |
| 21. I certify that I attended the deceased from <u>Dec</u> , 1958, to <u>Jan 18, 1959</u> , that I last saw the deceased alive on <u>Jan 16, 1959</u> , and that death occurred at <u>4810</u> M, from the causes and on the date stated above. | | | | | | |
| ACTUAL SIGNATURE <u>C. H. Metcalfe</u> M.D. ADDRESS (Street, city or town, state) <u>Poplarwood</u> DATE SIGNED <u>1/20/59</u> | | | | | | |
| PHYSICIAN'S NAME (Type) <u>C. H. METCALFE</u> | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF JAN. 21 | 22c. NAME OF CEMETERY OR CREMATORIAL ST. PETERS | 22d. LOCATION (City, town, or county) QUEENSTOWN | | (State) MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Hane</u> | | ADDRESS <u>Church Hill, Ind.</u> | 24a. REC'D BY REGISTRAR JAN 22 '59 | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2013 RELEASE UNDER E.O. 14176

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01087

1081

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | |
|--|--|---|--|----------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Centreville</i> | | c. LENGTH OF STAY IN 1b <i>all his life</i> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Centreville</i> | | |
| d. STREET ADDRESS <i>1 R 7 A # 3</i> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First <i>JAMES</i> | Middle <i>HARRY</i> | Last <i>LARRIMORE</i> | |
| 4. DATE OF DEATH <i>Jan 13 1959</i> | Month Year | Day | Year | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Aug 17-1870</i> | |
| 9. AGE (in years lost birthday) <i>88 yrs.</i> | 10. IF UNDER 1 YEAR Months <i>0</i> | 11. IF UNDER 24 HRS. Days <i>0</i> | 12. IF UNDER 24 HRS. Hours <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i> | 11. BIRTHPLACE (State or foreign country) <i>Queen Anne Co Md</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Edward J Larrimore</i> | 14. MOTHER'S MAIDEN NAME <i>Annie E Coster</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | 16. SOCIAL SECURITY NO. <i>None</i> | 17. INFORMANT <i>Henry Larrimore</i> | Address <i>Centreville Md</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>421.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Arteriosclerosis</i> | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | 20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town)</i> | (County) <i>Centreville</i> | (State) <i>Md</i> |
| 21. I certify that I attended the deceased from <i>Sept 1, 1958</i> to <i>Jan 13, 1959</i> that I lost saw the deceased alive on <i>Sept 17th, 1958</i> , and that death occurred at <i>Md</i> , from the causes and on the date stated above. | ADDRESS (Street, city or town, state) <i>Centreville Md</i> | | | |
| ACTUAL SIGNATURE <i>H.F. McPherson</i> | DATE SIGNED <i>1-14-59</i> | | | |
| PHYSICIAN'S NAME (Type) <i>H.F. McPherson</i> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>Jan 15-59</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Chesterfield</i> | 22d. LOCATION (City, town, or county) <i>Centreville Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Krasner</i> | ADDRESS <i>61 Main Street, Chesterfield, Centreville Md</i> | 24a. REC'D BY REGISTRAR DATE <i>JAN 16 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krasner</i> | |

DEPARTMENT OF STATE - BROWNSVILLE - TEXAS

CERTIFICATE OF DEATH

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| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | 101 | 102 | 103 | 104 | 105 | 106 | 107 | 108 | 109 | 110 | 111 | 112 | 113 | 114 | 115 | 116 | 117 | 118 | 119 | 120 | 121 | 122 | 123 | 124 | 125 | 126 | 127 | 128 | 129 | 130 | 131 | 132 | 133 | 134 | 135 | 136 | 137 | 138 | 139 | 140 | 141 | 142 | 143 | 144 | 145 | 146 | 147 | 148 | 149 | 150 | 151 | 152 | 153 | 154 | 155 | 156 | 157 | 158 | 159 | 160 | 161 | 162 | 163 | 164 | 165 | 166 | 167 | 168 | 169 | 170 | 171 | 172 | 173 | 174 | 175 | 176 | 177 | 178 | 179 | 180 | 181 | 182 | 183 | 184 | 185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 8010 | 8011 | 8012 | 8013 | 8014 | 8015 | 8016 | 8017 | 8018 | 8019 | 8020 | 8021 | 8022 | 8023 | 8024 | 8025 | 8026 | 8027 | 8028 | 8029 | 8030 | 8031 | 8032 | 8033 | 8034 | 8035 | 8036 | 8037 | 8038 | 8039 | 8040 | 8041 | 8042 | 8043 | 8044 | 8045 | 8046 | 8047 | 8048 | 8049 | 8050 | 8051 | 8052 | 8053 | 8054 | 8055 | 8056 | 8057 | 8058 | 8059 | 8060 | 8061 | 8062 | 8063 | 8064 | 8065 | 8066 | 8067 | 8068 | 8069 | 8070 | 8071 | 8072 | 8073 | 8074 | 8075 | 8076 | 8077 | 8078 | 8079 | 8080 | 8081 | 8082 | 8083 | 8084 | 8085 | 8086 | 8087 | 8088 | 8089 | 8090 | 8091 | 8092 | 8093 | 8094 | 8095 | 8096 | 8097 | 8098 | 8099 | 80100 | 80101 | 80102 | 80103 | 80104 | 80105 | 80106 | 80107 | 80108 | 80109 | 80110 | 80111 | 80112 | 80113 | 80114 | 80115 | 80116 | 80117 | 80118 | 80119 | 80120 | 80121 | 80122 | 80123 | 80124 | 80125 | 80126 | 80127 | 80128 | 80129 | 80130 | 80131 | 80132 | 80133 | 80134 | 80135 | 80136 | 80137 | 80138 | 80139 | 80140 | 80141 | 80142 | 80143 | 80144 | 80145 | 80146 | 80147 | 80148 | 80149 | 80150 | 80151 | 80152 | 80153 | 80154 | 80155 | 80156 | 80157 | 80158 | 80159 | 80160 | 80161 | 80162 | 80163 | 80164 | 80165 | 80166 | 80167 | 80168 | 80169 | 80170 | 80171 | 80172 | 80173 | 80174 | 80175 | 80176 | 80177 | 80178 | 80179 | 80180 | 80181 | 80182 | 80183 | 80184 | 80185 | 80186 | 80187 | 80188 | 80189 | 80190 | 80191 | 80192 | 80193 | 80194 | 80195 | 80196 | 80197 | 80198 | 80199 | 80200 | 80201 | 80202 | 80203 | 80204 | 80205 | 80206 | 80207 | 80208 | 80209 | 80210 | 80211 | 80212 | 80213 | 80214 | 80215 | 80216 | 80217 | 80218 | 80219 | 80220 | 80221 | 80222 | 80223 | 80224 | 80225 | 80226 | 80227 | 80228 | 80229 | 80230 | 80231 | 80232 | 80233 | 80234 | 80235 | 80236 | 80237 | 80238 | 80239 | 80240 | 80241 | 80242 | 80243 | 80244 | 80245 | 80246 | 80247 | 80248 | 80249 | 80250 | 80251 | 80252 | 80253 | 80254 | 80255 | 80256 | 80257 | 80258 | 80259 | 80260 | 80261 | 80262 | 80263 | 80264 | 80265 | 80266 | 80267 | 80268 | 80269 | 80270 | 80271 | 80272 | 80273 | 80274 | 80275 | 80276 | 80277 | 80278 | 80279 | 80280 | 80281 | 80282 | 80283 | 80284 | 80285 | 80286 | 80287 | 80288 | 80289 | 80290 | 80291 | 80292 | 80293 | 80294 | 80295 | 80296 | 80297 | 80298 | 80299 | 80300 | 80301 | 80302 | 80303 | 80304 | 80305 | 80306 | 80307 | 80308 | 80309 | 80310 | 80311 | 80312 | 80313 | 80314 | 80315 | 80316 | 80317 | 80318 | 80319 | 80320 | 80321 | 80322 | 80323 | 80324 | 80325 | 80326 | 80327 | 80328 | 80329 | 80330 | 80331 | 80332 | 80333 | 80334 | 80335 | 80336 | 80337 | 80338 | 80339 | 80340 | 80341 | 80342 | 80343 | 80344 | 80345 | 80346 | 80347 | 80348 | 80349 | 80350 | 80351 | 80352 | 80353 | 80354 | 80355 | 80356 | 80357 | 80358 | 80359 | 80360 | 80361 | 80362 | 80363 | 80364 | 80365 | 80366 | 80367 | 80368 | 80369 | 80370 | 80371 | 80372 | 80373 | 80374 | 80375 | 80376 | 80377 | 80378 | 80379 | 80380 | 80381 | 80382 | 80383 | 80384 | 80385 | 80386 | 80387 | 80388 | 80389 | 80390 | 80391 | 80392 | 80393 | 80394 | 80395 | 80396 | 80397 | 80398 | 80399 | 80400 | 80401 | 80402 | 80403 | 80404 | 80405 | 80406 | 80407 | 80408 | 80409 | 80410 | 80411 | 80412 | 80413 | 80414 | 80415 | 80416 | 80417 | 80418 | 80419 | 80420 | 80421 | 80422 | 80423 | 80424 | 80425 | 80426 | 80427 | 80428 | 80429 | 80430 | 80431 | 80432 | 80433 | 80434 | 80435 | 80436 | 80437 | 80438 | 80439 | 80440 | 80441 | 80442 | 80443 | 80444 | 80445 | 80446 | 80447 | 80448 | 80449 | 80450 | 80451 | 80452 | 80453 | 80454 | 80455 | 80456 | 80457 | 80458 | 80459 | 80460 | 80461 | 80462 | 80463 | 80464 | 80465 | 80466 | 80467 | 80468 | 80469 | 80470 | 80471 | 80472 | 80473 | 80474 | 80475 | 80476 | 80477 | 80478 | 80479 | 80480 | 80481 | 80482 | 80483 | 80484 | 80485 | 80486 | 80487 | 80488 | 80489 | 80490 | 80491 | 80492 | 80493 | 80494 | 80495 | 80496 | 80497 | 80498 | 80499 | 80500 | 80501 | 80502 | 80503 | 80504 | 80505 | 80506 | 80507 | 80508 | 80509 | 80510 | 80511 | 80512 | 80513 | 80514 | 80515 | 80516 | 80517 | 80518 | 80519 | 80520 | 80521 | 80522 | 80523 | 80524 | 80525 | 80526 | 80527 | 80528 | 80529 | 80530 | 80531 | 80532 | 80533 | 80534 | 80535 | 80536 | 80537 | 80538 | 80539 | 80540 | 80541 | 80542 | 80543 | 80544 | 80545 | 80546 | 80547 | 80548 | 80549 | 80550 | 80551 | 80552 | 80553 | 80554 | 80555 | 80556 | 80557 | 80558 | 80559 | 80560 | 80561 | 80562 | 80563 | 80564 | 80565 | 80566 | 80567 | 80568 | 80569 | 80570 | 80571 | 80572 | 80573 | 80574 | 80575 | 80576 | 80577 | 80578 | 80579 | 80580 | 80581 | 80582 | 80583 | 80584 | 80585 | 80586 | 80587 | 80588 | 80589 | 80590 | 80591 | 80592 | 80593 | 80594 | 80595 | 80596 | 80597 | 80598 | 80599 | 80600 | 80601 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|----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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01088

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | | |
|--|--|--|---|---|------------------------------------|---|------------------|------------|------------------------------|---------|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | | | | | | |
| Queen Anne MARYLAND | | | | a. STATE Delaware b. COUNTY Sussex | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. STREET ADDRESS | | | | | | |
| Grasonville - Rural | | 4 months | | Laurel | | 425 West Sixth Street | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| Kent Narrows | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First Sadie | Middle Mae | Lost | 4. DATE OF DEATH | Month J | Day 17 | Year 19 59 | | | | |
| 5. SEX | | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | | | |
| Female | | Negro | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | June 14, 1932 | 26 yrs. | Months | Days | Hours | Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Day Laborer | | | Oyster House | | | Laurel, Delaware | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | |
| James Blango | | | | Aline Brock | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | | |
| No | | 215-26-5624 | | Mrs. Aline Brock, Laurel, Delaware | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | | | |
| 626X Bilateral rupture of iliois abcess | | | | | | | | | | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | |
| DUE TO (c) | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 21, 1959 | | 22c. NAME OF CEMETERY OR CREMATORIUM New Zion Cemetery | | 22d. LOCATION (City, town, or county) Laurel, Delaware | | (State) | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland | | ADDRESS | | 24a. REC'D BY REGISTRAR Jan 26 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Turner | | | | | | |

No Pregnancy

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1083 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01089

Reg. Dist. No.

1 FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY <i>Queen Anne's</i> | | a. STATE <i>MARYLAND</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Queenstown</i> | | c. LENGTH OF STAY IN 1b <i>life</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Cuiterville</i> | |
| d. STREET ADDRESS <i>Easton Rd</i> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>JOHN DE BUTTS MOORE</i> | | 4. DATE OF DEATH <i>Jan 15 1959</i> | |
| First <i>JOHN</i> | | Middle <i>DE BUTTS</i> | |
| Last <i>MOORE</i> | | Month <i>Jan</i> | |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>July 17-1872</i> | |
| WIDOWED <input checked="" type="checkbox"/> | | DIVORCED <input type="checkbox"/> | |
| 9. AGE (In years last birthday) <i>86 yrs.</i> | | 10. IF UNDER 1 YEAR Months <i>0</i> | |
| 11. IF UNDER 24 HRS. Days <i>0</i> | | 12. IF UNDER 24 HRS. Hours <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Queen Anne's Co Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>US</i> | |
| 13. FATHER'S NAME <i>Samuel Moore</i> | | 14. MOTHER'S MAIDEN NAME <i>Sara J. Barber</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | |
| 17. INFORMANT <i>Mr. Franklin Day</i> | | 18. INFORMANT <i>Cuiterville Maryland</i> | |
| 19. INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>825X</i> | | 21. DUE TO <i>Fractionated Meas</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>None</i> | | 22. DUE TO (c) <i>None</i> | |
| 23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 25. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 26. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 20.) <i>Auto Accident</i> | |
| 27. TIME OF INJURY Month, Day, Year Hour 2 o. m. p. m. <i>1-15 1959</i> | | 28. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>On highway</i> | |
| 29. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Queen Anne's R.R. Da. Md</i> | | 30. (City or town) (County) (State) | |
| 31. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 32. ACTUAL SIGNATURE <i>H. F. McPherson</i> | |
| 33. EXAMINER'S NAME (Type) <i>H. F. McPherson</i> | | 34. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 35. DATE SIGNED <i>1-16-59</i> | | | |
| 36. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 37. DATE THEREOF <i>Jan 17-59</i> | |
| 38. NAME OF CEMETERY OR CREMATORIAL <i>Chesterville</i> | | 39. LOCATION (City, town, or county) (State) <i>Cuiterville Maryland</i> | |
| 40. FUNERAL DIRECTOR'S SIGNATURE <i>Edward B. Bunn</i> | | 41. ADDRESS <i>Cuiterville Md</i> | |
| 42. REC'D BY REGISTRAR <i>Arthur S. Evans</i> | | 43. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i> | |
| 44. DATE JAN 19 '59 | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 108 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01090

Reg. Dist. No.

| | | | |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. STATE <u>MD</u> b. COUNTY <u>24</u> | |
| c. LENGTH OF STAY IN lb | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) | | 4. DATE OF DEATH | |
| First <u>Merle</u> Middle <u>E</u> Last <u>Oberholzer</u> | | Month <u>Jan</u> Day <u>19</u> Year <u>1954</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9/25/1896</u> | 9. AGE (In years last birthday) <u>62</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 10c. <u>Milkman</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland City Pa</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>Reuben W. Laughlin</u> | |
| 14. MOTHER'S MADDEN NAME <u>Julie Murphy</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>123</u> | | 17. INFORMANT <u>Chas F. Oberholzer</u> Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary occlusion</u> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> | | | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | Month, Day, Year 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) <u>White Marsh</u> | | (County) <u>MD</u> (State) <u>MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>H. F. Matheson</u> | | DATE SIGNED <u>1/20/54</u> | |
| EXAMINER'S NAME (Type) <u>H. F. Matheson</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) | | 22b. DATE THEREOF <u>Jan. 23 1959</u> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Union Cemetery</u> | | 22d. LOCATION (City, town, or county) <u>White Marsh, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Elleror Millington Md.</u> | | ADDRESS | |
| | | 24a. REC'D BY REGISTRAR DATE <u>JAN 26 '59</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u> | |

